State of California-Health and Human Services Agency | Department of Health Services

Annual Physician Enrollment and Claim Certification Form
Fiscal Year 20____- 20____

☐ New Enrollment
☐ Recertification Enrollment

Emergency Medical Services Appropriation (EMSA)
Contract Back Program

This form is to be completed annually by JULY 1st, for each fiscal year in which the physician anticipates submitting claims for reimbursement from the EMSA Contract Back Program.

Attending Physician Information (Required)

1. Physician's Last Name | 2. Physician's First Name | 3. Zip Code

4. Mailing Address | 5. City

6. SSN or Federal Tax Number | 7. Medi-Cal Provider Number | 8. California Medical License Number | 9. State

10. Physician's Office Phone Number ( ) - | 11. Contact Person (if applicable)

Physician Group Information (If applicable)

12. Group Name | 13. Zip Code

14. Mailing Address | 15. City

16. Federal Tax Number | 17. Medi-Cal Group Number | 18. State

19. Group Office Phone Number ( ) - | 20. Contact Person (if applicable)

Physician/Group Billing Service Information (Required)

21. Name of Billing Service | 22. Zip Code | 23. State

24. Billing Service's Mailing Address | 25. City

26. Billing Service's Office Phone Number | 27. Contact Person (if applicable)

Warrant and Tax Information and Authorization

Issue warrants in the name of:
(select 1 or 2)
Warrants are to be mailed to:
(select 1, 2 or 3)

28. Warrant to:

29. Mail to:

1 Attending Physician
2 Physician Group
3 Billing Service

I authorize warrants to be issued in the physician's or physician group's name identified above, using the associated tax identification number indicated. The warrants are to be mailed to the address indicated.

EMSA USE ONLY

30. EMSA Enrollment Number

Date

Physician's Signature

Physician's Signature in BLUE INK (No Stamp/No Representative's Signature)

(Continued on reverse.)

Annual Physician Enrollment and Claim Certification (Page 2.)
EMSA Contract Back Program

Facility Information

In the following table identify all facility locations where you provide services that will be billed to the EMSA Contract Back Program. Billings for facilities not identified on this list will be returned unprocessed. A physician's office must be identified if services provided in the office will be billed to the EMSA Contract Back Program. For additional facilities, please use a second enrollment form.

Service Location Information

	Facility Name	Facility's Physical Address	County No.	Initial Certifying County.
1	31.	32.	33.	34.
2	35.	36.	37.	38.
3	39.	40.	41.	42.

Rendering Physician Certification

I certify that all claims submitted during this certification's fiscal year meet all the conditions and requirements of the EMSA Contract Back Program, pursuant to the EMSA Policies and Procedures Manual. Additionally, I certify that all claims submitted to the EMSA Contract Back Program for reimbursement will meet the following statutory conditions:

- The claim(s) has not been paid in WHOLE or PART by: the patient, any private insurance carrier, any program funded in whole or part by the federal government (i.e., Medi-Cal, Medicare, California Children's Services, etc.), or ANY other payor source.
- The attending physician/physician group/billing service has and will maintain documentation indicating that a third party payor source inquiry has been made AND that the patient or the responsible financial party has been billed for payment of services on three occasions.
- The attending physician/physician group/billing service has and will maintain documentation indicating that: 1) a period of not less than three months has passed from the date the patient or responsible third-party was last billed, during which time reasonable efforts were made to obtain reimbursement and that no reimbursement for ANY portion of the amount has been received; or 2) actual notification from the patient or responsible third-party has been received indicating that no payment will be made for the services rendered by the physician.

(Source: Welfare & Institutions Code, Sections 16952(f) and 16955(a)(b)(c))

"Notice of Privacy Practices" Agreement

By enrolling into the EMSA Contract Back Program, I, as the attending physician, acknowledge and understand my responsibility to provide patients with a copy of the "Notice of Privacy Practices" for the EMSA Contract Back Program in order to submit claims to the Program. This is in addition to any "Notice of Privacy Practices" which I give my patients as a medical provider. If a patient has not met their financial obligation for medical services received, I will or will instruct my billing service to, at the time of the third billing attempt, provide the patient, parent and/or responsible guardian with a copy of the "Notice of Privacy Practices" for the EMSA Contract Back Program.

I also understand that my responsibilities and obligations include, but are not limited to, the preparation, maintenance, and retention of service and financial records pertaining to any claims submitted, and the availability of those records for review and audit. I also understand that I am responsible for refunding all claim overpayments and providing restitution for any audit exceptions identified during an EMSA Contract Back Program case review.

Date Physician's Signature
(No Stamp/No Representative's Signature)

Representative Authorization

I authorize _____ of (group/billing service name) _____ to act on my behalf for the submission of all documents required for reimbursement of eligible uncompensated medical services provided by me personally.

Date Physician's Signature